

Early Learning Application 2018-2019

STAFF ONLY	Date received:	Site Name/ID:	❖ ELMS Prescreen Questions	☐ + ☉ TOTAL	Child's Age
	Date staff reviewed application with family:	HS/EHS ONLY - Date sent to PSESD:			
	Is this child a newborn taking the mother's slot? ☐ Yes ☐ No If yes, mother's name:	Is this child currently enrolled in a community slot at this center? ☐ Yes ☐ No Is this child's sibling currently enrolled in a community slot at this center? ☐ Yes ☐ No		☉	

The information on your application is confidential and used only to determine your child's eligibility for our Early Learning Programs. We do not require, check, or report on immigration status.

CHILD INFORMATION	Child Information	
	❖ First Name:	Middle Initial: Last Name:
	❖ Date of Birth: ___/___/___ Month/Day/Year Please include proof of birth date with this application	❖ Gender:
	Collecting the information below helps us to determine the most culturally appropriate services and supports unique to your child and family.	
	❖ What is your child's home language? _____	
	❖ Is your child Hispanic/Latino? ☐ Yes - Please describe or write the country of origin: _____ ☐ No	
	❖ What is your child's race? Check all that apply: ☐ African/African American/Black ➤ Please describe or write the tribe/country of origin: _____ ☐ Asian ➤ Please describe or write the tribe/country of origin: _____ ☐ Alaska Native/Native American/American Indian ➤ Please describe or write the tribe/country of origin: _____ ☐ Native Hawaiian or Pacific Islander ➤ Please describe or write the tribe/country of origin: _____ ☐ White ➤ Please describe or write the tribe/country of origin: _____ If not listed above, please describe your child's heritage: _____	
	Has your child previously attended any of these programs? ☐ Birth-to-3 Home Visiting Program ☐ Head Start ☐ Early Support for Infants and Toddlers (ESIT) ☐ Migrant/Seasonal Head Start anywhere in Washington ☐ Early Head Start ☐ ECEAP ☐ Parents as Teachers ☐ No	
	When did your child last attend? _____ Name and location of program: _____	
	❖ Is your child in official foster/kinship care? (A caregiver authorization from a state or tribe that says child is a foster/kinship placement) ☐ Yes ☐ No ➤ Has your child been in foster/kinship care in the past? ☐ Yes ☐ No	
Has your child ever been asked to leave a childcare center or preschool because of behavior issues? ☐ Yes ☐ No		
Has your child experienced abuse or neglect? ☐ Yes ☐ No		
Has your child been diagnosed by a Health Care Provider with one or more serious/chronic health conditions, such as asthma, diabetes, seizures, heart condition, or life-threatening allergies? ☐ Yes - Please describe: _____ ☐ No		

CHILD INFORMATION	Child Information		
	Do you suspect that your child has a developmental delay or disability?		
	<input type="checkbox"/> Yes - Please describe: _____		<input type="checkbox"/> No
	Does your child have a current Individual Family Service Plan (IFSP) or Individual Education Plan (IEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please answer the following questions and include a copy of the IFSP or IEP with this application		
	➤ Please check all categories of the IEP/IFSP:		
	<input type="checkbox"/> Autism	<input type="checkbox"/> Intellectual disability	<input type="checkbox"/> Specific learning disability
<input type="checkbox"/> Deaf-blindness	<input type="checkbox"/> Multiple disabilities	<input type="checkbox"/> Speech/language impairment	
<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Orthopedic impairment	<input type="checkbox"/> Traumatic brain injury	
<input type="checkbox"/> Emotional disturbance	<input type="checkbox"/> Other health impairment	<input type="checkbox"/> Visual impairment	
<input type="checkbox"/> Hearing impairment			
➤ Is Special Ed Preschool or Birth-to-3 Program available/easily accessible to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know			
Do you have concerns about your child's health and development? Check all that apply:			
<input type="checkbox"/> Low birth weight (less than 5.8 lbs.)	<input type="checkbox"/> Mental health - Please describe: _____	<input type="checkbox"/> Behavior - Please describe: _____	

<input type="checkbox"/> Hearing	<input type="checkbox"/> Food intolerance/special diet - Please describe: _____	<input type="checkbox"/> Speech/language	
<input type="checkbox"/> Vision		<input type="checkbox"/> Fine motor/gross motor	
<input type="checkbox"/> Tooth pain/decay/bleeding gums		<input type="checkbox"/> Other - Please specify: _____	
<input type="checkbox"/> Drug/alcohol affected			
Does this child have medical insurance?			
<input type="checkbox"/> Yes - What type?			
➤ <input type="checkbox"/> Washington Apple Health/ProviderOne <input type="checkbox"/> Private Insurance <input type="checkbox"/> Tribal or Military Medical Coverage			
<input type="checkbox"/> No			
Does this child have a regular doctor or medical clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did this child have a well-child exam within the last 12 months? <input type="checkbox"/> Yes - Date of last exam: ___/___/___ <input type="checkbox"/> Date Unknown <input type="checkbox"/> No			
Does this child have dental insurance?			
<input type="checkbox"/> Yes - What type?			
➤ <input type="checkbox"/> Washington Apple Health/ProviderOne <input type="checkbox"/> Private Insurance <input type="checkbox"/> Tribal or Military Dental Coverage			
<input type="checkbox"/> No			
Does this child have a regular dentist or dental clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did this child have a dental screening in the last 6 months? <input type="checkbox"/> Yes - Date of last screening: ___/___/___ <input type="checkbox"/> Date Unknown <input type="checkbox"/> No			

FAMILY INFORMATION	Family Information	Parent/Guardian 1	Parent/Guardian 2
	❖ Name:		
	❖ Relationship to Child:	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other	<input type="checkbox"/> Biological/Adopted/Stepparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Other Relative <input type="checkbox"/> Other
	❖ Date of Birth:	___/___/___ Month/Day/Year	___/___/___ Month/Day/Year
	How old were you when this child was born?	_____	_____
	❖ Address:		
	❖ Phone:	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	❖ Alternate Phone:	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	____-____-____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
❖ Email Address:			

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FAMILY INFORMATION	Family Information	Parent/Guardian 1	Parent/Guardian 2	
	❖ Do you need an interpreter? ❖ What language(s) do you speak?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/>
	Did you get a high school diploma or GED? What is the highest degree you completed?	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None - What is the highest grade you completed? _____ <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> None	<input type="checkbox"/> GED <input type="checkbox"/> High school diploma <input type="checkbox"/> None - What is the highest grade you completed? _____ <input type="checkbox"/> Some college/advanced training <input type="checkbox"/> College degree/professional certificate <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> None	<input type="checkbox"/>
	❖ Are you currently employed? ❖ Are you currently in job training or school?	<input type="checkbox"/> Yes - How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal <input type="checkbox"/> Yes - How many hours per week? _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - How many hours per week? _____ <input type="checkbox"/> No <input type="checkbox"/> Retired/Disabled <input type="checkbox"/> Seasonal <input type="checkbox"/> Yes - How many hours per week? _____ <input type="checkbox"/> No	
	❖ Are you in an approved WorkFirst activity?	<input type="checkbox"/> Yes - Describe the activity and number of approved hours per week: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes - Describe the activity and number of approved hours per week: _____ <input type="checkbox"/> No	
	Are you on active U.S. military duty? Are you a member of a National Guard or Military Reserve unit? Are you a U.S. military veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Please check areas of concern that you have for yourself/family in your household that we may be able to assist you with:			<input type="checkbox"/>
	<input type="checkbox"/> Previously homeless (in the last 12 months) <input type="checkbox"/> Household mental illness/counseling, including maternal depression. <input type="checkbox"/> Child's parent/guardian is disabled <input type="checkbox"/> Child's parent/guardian is a migrant worker <input type="checkbox"/> Child's parent/guardian is currently deployed to a combat zone, or was within the last year <input type="checkbox"/> Household domestic violence (past or current) <input type="checkbox"/> Child's parent/guardian is incarcerated <input type="checkbox"/> Household drug/alcohol issues or substance abuse <input type="checkbox"/> Family has little or no support from other family or friends			
	<input type="checkbox"/> Other household members have no medical/dental insurance <input type="checkbox"/> Getting or keeping a job <input type="checkbox"/> Other household members have no medical/dental home <input type="checkbox"/> Concerns with housing <input type="checkbox"/> Child's parent/guardian has health concerns <input type="checkbox"/> Legal concerns <input type="checkbox"/> Child's parent/guardian has learning difficulties <input type="checkbox"/> Recent immigrant/refugee (past 5 years)			<input type="checkbox"/>

If you are employed, what is the name of your employer?

If you are in job training or school, what is the name of your school?

Family Information				
❖ Child lives with: <ul style="list-style-type: none"> ➢ <input type="checkbox"/> One parent/guardian ➢ <input type="checkbox"/> Two parents/guardians in same household ➢ <input type="checkbox"/> Two parents/guardians in two households – Does one household have primary legal custody? <ul style="list-style-type: none"> ➢ <input type="checkbox"/> Yes – Which parent has primary custody? _____ ➢ <input type="checkbox"/> No – Does one parent receive child support payments from the other household? <ul style="list-style-type: none"> ➢ <input type="checkbox"/> Yes – Which parent receives the child support payments? _____ ➢ <input type="checkbox"/> No 				
❖ Please list other people living in your home. Do not include yourself or your child. If you need more space, write on a separate piece of paper and include with your application.				Staff Only - Family Size:
Name (First and Last)	Birthdate (Month/Day/Year)	Relationship to Child	Do you financially support this person?	Is this person related to you by blood, marriage, or adoption?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
❖ Does this child live with a guardian who is not their parent or foster parent? <ul style="list-style-type: none"> ➢ <input type="checkbox"/> Yes <ul style="list-style-type: none"> ➢ Does this person receive a state, tribal, or SSI payment on behalf of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No ➢ <input type="checkbox"/> No 				
Do you, your child, or another member of your family receive these types of income? Check all that apply:				
<input type="checkbox"/> TANF <ul style="list-style-type: none"> ➢ Is it for child only? <input type="checkbox"/> Yes <input type="checkbox"/> No ➢ Do you have a Working Connections Child Care Subsidy? <input type="checkbox"/> Yes <input type="checkbox"/> No 				
<input type="checkbox"/> Supplemental Security Income (SSI) for disability <ul style="list-style-type: none"> ➢ Person's relationship to child: _____ 				
<input type="checkbox"/> Foster Child Income				
❖ Total estimated household income for the last calendar year or the last 12 months: _____ Please include proof of income and family size with this application.				
❖ Does your family currently receive services through Child Protective Services (CPS), Family Assessment Response (FAR), or Indian Child Welfare (ICW)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
❖ Is your family currently approved for child care through CPS or FAR? <input type="checkbox"/> Yes – Number of approved hours per week: _____ <input type="checkbox"/> No				
❖ Has your family received services from CPS or ICW in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No				
❖ What is your family's current housing situation? <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Other – If this is checked, please complete the attached <i>Housing Questionnaire</i>				
Does this household receive subsidized housing, such as a housing voucher or cash assistance for housing? <input type="checkbox"/> Yes <input type="checkbox"/> No				
❖ How did you learn about our program? Check all that apply:				
<input type="checkbox"/> Website <input type="checkbox"/> Community event <input type="checkbox"/> Flyer <input type="checkbox"/> Media <input type="checkbox"/> Word of mouth <input type="checkbox"/> Site staff <input type="checkbox"/> Past parent				
<input type="checkbox"/> Community agency/Case worker – Please specify: _____ <input type="checkbox"/> Other – Please specify: _____				

I have answered the questions to the best of my knowledge and have provided the requested documentation that I have available.

Parent/Guardian Signature: _____ Date: _____
 (ECEAP Staff: Enter this date in ELMS)